VERMONT DEPARTMENT OF HEALTH AIDS PROGRAM
RELEASE OF INFORMATION

I, _____, authorize the Vermont Department of Health
(Print Name)
HIV/AIDS Program staff to receive and disclose medical, dental, insurance, and eligibility information pertaining to my HIV-related condition to and from the service providers listed below. I understand that information will be disclosed only to determine eligibility for the HIV/AIDS Assistance Programs or to arrange for payments on my behalf for these programs. I also understand that information will be disclosed only on an as needed basis and only to the necessary providers and programs.

X Department of Prevention, Assistance, Transition and Health (PATH, formerly DSW)
X Physician and treating facility
X AIDS Service Organization case manager (Name_____)
X Dental Provider
X Pharmacy
X Social Worker (Name_____)
X Vermont Dept. of Health AIDS Service Programs (Dental, Insurance, Medication)

__ Spouse/Domestic Partner/Partner in a Civil Union (Name_____)

__ Family member (Specify _____)

___Other (specify_____)

Patient's Signature_____**Date**_____

Please return this form with completed application(s) to

Moretti, VT Dept of Health
108 Cherry St., Drawer 41 HAST
P.O. Box 70
Burlington, VT 05402-0070
(802) 863-7253 or 1-800-464-4343 ext 7253.

Thank you.